| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155224 | A. BUILDING _____ B. WING _____ | 03/16/2011 |

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| COLUMBIA HEALTHCARE CENTER | 621 WEST COLUMBIA STREET EVANSVILLE, IN47710 |

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| F0000 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00086764.<br><br>Complaint IN00086764 - Substantiated. No deficiencies related to the allegations were cited.<br><br>Survey dates:<br>March 8, 9, 10, 11, 14, 15, 16, 2011<br><br>Facility number: 000129<br>Provider number: 155224<br>AIM number: 100266780<br><br>Survey team:<br>Diane Hancock, RN TC<br>Sue Webster, RN<br>Jodi Meyer, RN<br>Guylene Maurer, RD<br>3/8, 3/9, 3/10, 3/11, 3/14/11<br><br>Census bed type:<br>SNF/NF 119<br>Total 119<br><br>Census payor type:<br>Medicare 18<br>Medicaid 92<br>Other 9<br>Total 119 | F0000 | The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.<br><br>This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review on or after April 4, 2011. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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| | Sample: 24<br>Supplemental sample: 1<br><br>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review 3/17/11 by Suzanne Williams, RN | | | |

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| F0223 SS=A | Based on record review and interview, the facility failed to ensure 1 of 1 supplemental sample resident reviewed, with an allegation of physical and/or verbal abuse (Resident #22), in the supplemental sample of 1, was free of physical and/or verbal abuse, in that the resident complained of rough treatment during care and verbal rudeness from a staff member. (CNA #7)<br><br>Finding includes:<br><br>On 3/10/11 at 3:30 p.m., the Director of Nurses provided two investigations of allegations of abuse for review and they were reviewed at that time.<br><br>One of the allegations was made by Resident #22. She had reported to a facility RN, on 1/15/11 at 1400 [2:00 p.m.], that CNA #7 was "rough with care, verbally rude and then came back to apologize." The RN reported it immediately to the Administrator and Director of Nursing. A full body assessment was completed on Resident #22; no injuries were noted. A psychosocial assessment was also completed.<br><br>The facility immediately suspended CNA #7, on 1/15/11, and began an | F0223 | F223 Free From Abuse/Involuntary Seclusion<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #22 had a full body assessment completed at the time of the allegation, with no injuries noted. · Resident # 22 had a psychosocial assessment completed with no negative outcomes. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Facility will continue to monitor for abuse. Facility will continue to inservice staff upon hire and quarterly on abuse. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Staff will be inserviced on Abuse definitions and policy and procedure. · Executive Director is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · An Abuse CQI tool will be utilized weekly times four, and | 04/04/2011 |

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| | investigation. The investigation included statements from other staff working with CNA #7 and interviews with other residents cared for by CNA #7.<br><br>Based on their review, they determined that Resident #22 was alert and oriented. One other resident indicated the CNA had been rough with her in the past. It was determined that the CNA was rough with the resident and rude and they terminated the CNA.<br><br>The facility had done pre-employment reference and criminal history checks, based on employee file reviews on 3/10/11 at 2:30 p.m. Review of inservices indicated the facility had provided abuse inservices in the past 6 months.<br><br>On 3/15/11 at 4:00 p.m., the Director of Nurses and the Administrator were interviewed. They indicated they did believe the CNA had been rough with the resident and rude, and she had a previous allegation that wasn't able to be substantiated, so they terminated the CNA.<br><br>The Director of Nurses indicated, on 3/16/11 at 11:15 a.m., the facility had held another inservice on abuse on 1/25/11. | | monthly thereafter. ·<br>Non-compliant issues will be brought to the executive director immediately and brought before the Continuous Quality Improvement Committee monthly.<br>**Compliance date: April 4, 2011** | |

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| | 3.1-27(b) | | | |

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| F0428 SS=D | Based on record review and interview, the facility failed to ensure pharmacist recommendations were acted upon, for 1 of 21 sampled residents reviewed for pharmacy recommendations, in the total sample of 24, in that the physician agreed with a recommendation to decrease a psychoactive medication and it was not done. (Resident #93)<br><br>Finding includes:<br><br>On 3/14/11 at 3:05 p.m., Resident #93's clinical record was reviewed. A pharmacy recommendation was reviewed, dated 1/19/11. The pharmacist recommended decreasing the resident's Abilify [medication to treat schizophrenia] from 20 milligrams [mg] to 15 mg daily, and to discontinue prn [as needed] lorazepam [anti-anxiety medication] due to non-use. The physician indicated he agreed with the recommendations.<br><br>There was no indication the orders had been completed and the medications had been discontinued and/or decreased.<br><br>The Assistant Director of Nurses indicated, during interview on 3/14/11 at 4:40 p.m., she found orders to discontinue the lorazepam, dated 1/17/11. The order to decrease the Abilify was never | F0428 | F428 Drug Regimen, Report Irregular, Act On **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident and Physician were notified of pharmacy recommendation for reduction of Abilify for resident #93. An order was obtained to reduce resident #93's Abilify per pharmacy recommendation. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · Residents receiving pharmacy recommendations have the potential to be affected by the alleged deficient practice. · An audit of pharmacy recommendations for the last 90 days will be completed to ensure they have been acted upon. Any deficiencies found will be corrected including notifications of responsible party and physician.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Assistant Director of nursing services/designee will bring pharmacy recommendations to IDT meeting for review prior to sending for physician orders. · A binder will be maintained with copies of pharmacy | 04/04/2011 |

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| | obtained/followed through on, she indicated. She proceeded to call the physician and get the order to decrease the Abilify from 20 mg per day to 15 mg per day.<br><br>The Pharmacy/Consulting Services policy and procedure was provided by the Consultant Nurse, on 3/15/11 at 3:33 p.m. It was not dated. The policy included, but was not limited to, the following:<br>"Drug Regimen Review"<br>"-Pursuant to Federal and State regulations, the clinical consultant pharmacist conducts a periodic review in accordance to these regulations of each resident's medication regimen in the facility and signs the patients medical chart.<br>-The consultant will assist the nursing staff in implementing the policies and procedures as set forth by the Quality Assurance Committee."<br><br>3.1-25(j) | | recommendations and the attached follow-up orders. · Recommendations will be tracked by IDT meeting daily Monday-Friday for follow through and timeliness. · Nurse managers have been inserviced on drug regimen review policy & procedure and this systemic change. · A pharmacy services CQI audit tool will be completed weekly times one month, monthly times 3 months and quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A pharmacy services CQI audit tool will be completed weekly times one month, monthly times 3 months and quarterly thereafter. · Findings from the pharmacy services CQI tool will be reviewed monthly and an action plan will be implemented as needed for any deficient practices. · Non-compliance with facility policy and procedure may result in employee disciplinary action up to and including termination. **Compliance date: April 4, 2011** | |

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| F0441 SS=D | Based on observation, interview and record review, the facility failed to ensure hands were washed when gloves were removed between soiled and clean procedures, during 1 of 2 observations of dressing changes for 1 of 2 sampled residents with open areas, in the sample of 24. (LPN #1, Resident #63)<br><br>Finding includes:<br><br>During the initial tour, on 3/8/11 at 2:31 p.m., Resident #63 was identified, by the touring nurse RN #1, as having been admitted with a stage three area on her coccyx [full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss].<br><br>The clinical record was reviewed on 3/9/11 at 10:00 a.m. The record contained diagnoses that included, but were not limited to, non healing decubitus ulcer, diabetes mellitus, end stage renal disease, and neuropathy.<br><br>The interdisciplinary team progress notes, dated 3/3/11, identified resident #63 having a stage three, 2 cm [centimeter] by 3 cm open area on the coccyx. | F0441 | F441 Infection Control, Prevent Spread, Linens. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #63's wound is healing and was not adversely affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who receive wound treatments have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nursing Staff have been inserviced on washing hands between glove changes by the Director of nursing on March 22, 2011. · Staff also completed a hand washing skills validation. · Director of Nursing/designee is responsible to ensure compliance. · Proper handwashing diagrams have been placed near time clock and in employee break room as a reminder and review of handwashing procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur,** | 04/04/2011 |

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| | On 3/11/11 at 10:20 a.m., LPN #1 was observed during a dressing change to the area. The following was observed: LPN #1 donned gloves, removed the soiled dressing, changed her gloves, applied a spray wound cleanser to a gauge pad, wiped the area, changed her gloves, applied normal saline to a small blue pad before placing it in the wound, changed her gloves and applied an Allevyn [foam] dressing over the area.<br><br>No hand washing or use of alcohol gel was used during the treatment, between the soiled contact and the clean.<br><br>On 3/15/11 at 3:33 p.m. the Corporate Compliance Nurse provided a copy of the facility's current policy, no date, related to handwashing. The policy Standard was, "Handwashing is the single most important factor in preventing transmission of infections. Inadequate handwashing has been responsible for many outbreaks of infectious disease in LTCF [long term care facilities]. Implementation of PROPER handwashing practices has interrupted outbreaks in many settings."<br><br>The Policy included the following: "All health care workers shall wash their hands frequently and appropriately..." The times | | **i.e., what quality assurance program will be put into place?**<br>· An Infection Control/Handwashing CQI tool will be utilized 3 times weekly times four, monthly times three, then quarterly thereafter. · Non-compliant issues will be brought before the Continuous Quality Improvement Committee monthly times three and then quarterly times three. · Non-compliant staff may receive re- education and/or disciplinary action. **Compliance date: April 4, 2011** | |

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| | when the workers were to wash their hands, included, but were not limited to, "After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc."<br><br>3.1-18(l) | | | |